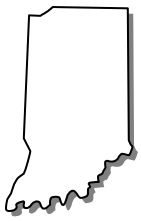

INDIANA HEALTH COVERAGE PROGRAMS

Chapter 1: Introduction

Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	December 31, 1999	All	Updated edits and audits	Leanna Collisi and Brandy Ludlum

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Section 1: Introduction

Overview

This manual is designed to provide the user with detailed descriptions on all edits and audits within the Indiana*AIM* system.

Edits are designed to verify data submitted on the claim form and ensure that claims are being submitted with the necessary data to process the claim.

Audits are designed to compare the claim being processed to claims that have already been paid (paid history), thus ensuring that claims are being paid within policies set forth by the Office of Medicaid Policy and Planning (OMPP) and the Health Care Financing Administration (HCFA).

The purpose of this manual is to provide the user with step-by-step instructions on processing claims based on the edits and audits indicated in this manual and to provide the user with a full understanding of how these edits and audits function.

Edits and audits under the Indiana*AIM* system are divided into 10 categories:

- Validation Edits – numbered from 0001 through 0499
- Relational Edits – numbered from 0500 through 0599
- Provider Edits – numbered from 1000 through 1999
- Recipient Edits – numbered from 2000 through 2999
- Prior Authorization Edits – numbered from 3000 through 3999
- Reference Edits – numbered from 4000 through 4999
- History Related Audits – numbered from 5000 through 5999
- Medical Policy Audits – numbered from 6000 through 6999
- SURS Edits – numbered from 7000 through 7999
- Miscellaneous Edits – numbered from 9000 through 9999

Figure 1-1.1 is a sample of information included as a table for each edit or audit in this manual. Figure 1.1 shows the layout of this table found with each edit or audit as well as a description of the information contained within each column of the table.

Edit or Audit: ESC (Number and Name)

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
Indicates which claim type(s) is applicable to the specific edit or audit.	Indicates the location of a claim in the system and the area or unit responsible for calculating reimbursement or denial of a claim that suspends for a particular edit or audit.	The medical assistance program(s) for which the edit or audit applies.	*Header* indicates that the edit or audit sets at the header level of the claim form. Claim types which price at the header **or** dates of service found only in the header would be classified as 'header' claim types. When a claim fails an edit or audit at the header level, the entire claim is denied. Header claim types are: A, B, C, I, L, P, and Q. Or *Detail* indicates that the edit or audit sets at the detail level of the claim form. Claim types which price at the detail **or** have dates of service at the detail would be classified as 'detail' claim types. When a claim fails an edit or audit at the detail level, only that detail is denied, unless all details are denied, in which case the whole claim denies. Detail claim types are: D, H, M, and O.	Mechanism that allows an analyst to force a particular edit or audit if certain criteria are met. If forced, the edit or audit's EOB will post to the remittance advice (RA).	Mechanism that allows an analyst to deny a particular edit or audit based on certain criteria.	The day that claims are reprocessed through the system. This function is currently not operational.

Figure 1-1.1 – Individual Edit or Audit Information Table

The information contained in Figure 1-1.2 is a description of the information contained within the region and disposition table included for each edit or audit in this manual. Following Figure 1-1.2 are examples of the other information included for each audit and a description of the information found there.

Region	Description
Paper Claim (10)	A claim that is submitted for services rendered on paper rather than by electronic means.
Paper Claim w/attachment (11)	A claim that is submitted for services rendered on paper with an attached document that indicates justification for the services rendered. The provider may also use a claim attachment to send a specific message to the carrier or to fulfill a specific requirement.
ECS (20)	Claim data submitted electronically through National Electronic Claim Submission (NECS) or vendor software directly into Indiana*AIM* for processing. NECS software was developed by EDS and is supplied to providers who have the capability and desire to submit claims electronically at their point of sale.
Shadow (22)	Claim paid for a recipient by a managed care organization (MCO) that is entered into the Indiana*AIM* system to monitor the recipient's use of program services.
POS (25)	A billing system that uses swipe card or personal computer technology to bill for services rendered at the provider's place of service. This type of claim submission is currently only used by pharmacies.
Adjustments (50, 51)	A transaction that reprocesses a previously paid claim.
Special Batch (90)	Claims that are given special consideration when processed through the Indiana*AIM* system. Claims are special batched if they meet specific criteria, such as being requested by the OMPP, State Legislator, or Attorney General.
Disposition	**Appropriate Action To Be Taken**
Deny	Indicates that the claim or the detail will systematically be denied if the edit or audit is set.
Pay	Indicates that the claim or the detail will systematically pay and post the EOB to the RA if the edit or audit is set.
Suspend	Indicates that the claim will systematically suspend for an analyst to review if the edit or audit is set.
CCF (Claim Correction Form)	Indicates that a CCF will be systematically generated to the provider if the edit or audit is set. The CCF must be returned by the provider and the data entered within 45 days or the claim will automatically deny.

Figure 1-1.2 – Region and Disposition Table

Edit/Audit Description

Overview for the purpose of the edit or audit.

Edit/Audit Criteria

Detailed criteria on what will or will not cause the edit or audit to set.

EOB Code

A claim summary statement which is posted on the RA if the edit or audit is set.

Method of Correction

Instructions used by the analyst to process the claim according to specific guidelines set up for the particular edit or audit.

Document Conventions

This document uses specific typographic and computer-related conventions. These standard text formats and visual clues make a document easier to use and understand.

Typographic Conventions

Changes in font or typeface draw attention to information because it looks different. Information is placed in boldface or italic type because it provides a visual signal to the reader about the information.

Boldface type is used:

- To emphasize important information. Use emphasis sparingly, if at all.
- To call out individual characters within the text.

  Example: The plural form of most words is made by adding an **s** to the singular form of the word.
- To indicate computer commands or text the reader must type at computer prompts.

  Example: Type **edsnet** at the prompt.

Italicize words to indicate the following:

- Words defined in the text, either explicitly or by context. If a term needs a definition, the definition appears after the term's first use in the document.

  Example: In Microsoft Word, a *style name* defines a set of character formats and paragraph formats.
- Titles
  - Books, including EDS reference manuals
  - Films and videotapes
  - Magazines and journals
  - Courses
- References to other sections of the current document or to external resources
- File names and directory paths
- Foreign words, unless they are commonly used in English
- Variables in mathematical equations or text

Technical documents often include additional conventions that add more information to the printed word of a particular document. Changes to the font may distinguish between information that is typed by the user or printed on the monitor screen. Typographic conventions can even protect the readers by drawing attention to information protection issues.

Computer-Related Conventions

Procedures within a document often include actions performed in a computer-related environment.

When typing a series of computer commands, the following conventions apply:

- Use a numbered list to show a series of actions in the order they are completed.
- The numbered list should follow a complete sentence. Complete sentences should also follow the numbered list.
- Use punctuation in each step. Each step is a complete sentence (the subject is implied with commands).
- Follow all other document conventions

In column one of Table 1-1.1, keys, keyboard combinations, and mouse commands are shown as they appear in the printed text of the document.

Table 1-1.1 – Computer-Related Conventions

Text Sample	Meaning
Click	Press the left mouse button once. Click buttons, icons, and menu item selections. Use click, do not use select.
Double-click	Press the left mouse button twice in quick succession. Double-click is always hyphenated.
Right-click	Press the right mouse button once. Right-click is always hyphenated.
Press	Press keys. Do not hit or strike.
Type	Type characters on a keyboard. Do not use **Enter**, key, or input to mean *type*.
A plus sign between key names *Examples:* Press **Ctrl**+**Tab**. Press **Ctrl**+**Alt**+**Del**.	Press two or more keys simultaneously.
A comma is used between key names. *Examples:* Press **Alt**, **spacebar**. Press **Alt**, **F**.	Press two or more keys sequentially (that is, pressing and releasing one key before pressing another key).

Common Acronyms and Initialisms

Table 1-1.2 lists several commonly used acronyms and initialisms used throughout this manual. They are provided in this table as a reference.

Table 1-1.2 – Common Acronyms and Initialisms

Acronym/Initialism	Definition
8-A	DPW Form 8A, Notice to Provider of Recipient Deductible
AA	Anesthesia
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AIM	Advanced Information Management system
ANSI	American National Standards Institute

(Continued)

Table 1-1.2 – Common Acronyms and Initialisms

Acronym/Initialism	Definition
AR	Accounts Receivable
ARCH	Assisted Residential County Homes
ASC	Ambulatory Surgical Center
AWP	Average wholesale price
BCBS	Blue Cross/Blue Shield
CCF	Claim correction form
CDPW	County Department of Public Welfare
CHAMP	Change and Management Member Promotion
CICS	Customer Information Control System
CLIA	Clinical Laboratory Improvement Amendments
CPAS	Claims Processing Assessment System
CPHA	Commission on Professional and Hospital Activities
CPT	Current Procedural Terminology
CRF/DD	Community Residential Facility for the Developmentally Disabled
CRNA	Certified Registered Nurse Anesthetist
CSHCS	Children's Special Health Care Services
CSR	Customer Service Request
DBA	Doing Business As
DD	Developmentally disabled or developmental disabilities
D & E	Diagnostic and Evaluation (in reference to services/providers)
DEA	Degree of potential abuse and federal control of drugs
DESI	A drug with a designation of 5 or 6 that has been determined to be less than effective by HCFA (LTE; not covered by the Indiana Medicaid Assistance Programs
DHS	Department of Human Services
DIP	Detailed Implementation Plan
DME	Durable medical equipment
DOS	Date of Service
DPW	Department of Public Welfare
DRG	Diagnosis-related grouping
DUR	Drug Utilization Review
EA	Each
EAC	Estimated acquisition cost
E-Code	Durable medical equipment codes
ECS	Electronic claims submittal
EDS	Electronic Data Systems
EFT	Electronic funds transfer
E & M	Evaluation and Management

(Continued)

Table 1-1.2 – Common Acronyms and Initialisms

Acronym/Initialism	Definition
EMC	Electronic media claims
EMG	Electromyography
EOB	Explanation of benefits
EOMB	Explanation of Medicare benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program
ESC	Error Status Code
ETN	Enrollment Tracking Number
FDOS	From Date of Service
FQHC	Federally Qualified Health Center
GM	Gram
GPCI	Geographic Practice Cost Index
GSG	Government Systems Group
HCBS	Home and Community-Based Services waiver programs
HCE	Health Care Excel
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HIC	Health insurance carrier number
HMO	Health maintenance organization
IAC	Indiana Administrative Code
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF/MR	Intermediate care facility for the mentally retarded
ICN	Internal control number
ID	Identification
IFSSA	Indiana Family and Social Services Administration
IHCP	Indiana Health Coverage Programs
LOC	Level-of-care
LTC	Long-term care
MARS	Management and Administrative Reporting Subsystem
MCO	managed care organization
MG	Milligram
ML	Milliliter
MMIS	Medicaid Management Information System
MPAP	Medical Policy Audit Processing
MPAR	Medical Policy Adjustment Request
MRO	Medicaid Rehabilitation Option
N/A	Not applicable
NDC	National Drug Code

(Continued)

Table 1-1.2 – Common Acronyms and Initialisms

Acronym/Initialism	Definition
NECS	National Electronic Claims Submission
NF	Nursing Facility
NH	Nursing Home
OMPP	Office of Medicaid Policy and Planning
OTC	Over-the-counter
PA	Prior authorization
PAS	Professional activities study; document of statistical healthcare data used for prior authorization guidelines
PASARR	Preadmission Screening and Resident Review
PCCM	Primary care case management
PCN	Patient Control Number
PMP	Primary medical provider
POS	Place of service or point of sale (depending on situation)
ProDUR	Prospective Drug Utilization Review
PS & RR	Provider Statistical and Reimbursement Report
QDWI	Qualified disabled working individual
QI	Qualified Individual
QMB	Qualified Medicare beneficiary
RA	Remittance advise
RBMC	Risk-based managed care
RBRVS	Resource-based relative value scale
REI	Recognition Equipment Incorporated
RID	Recipient Identification
SDPW	State Department of Public Welfare (replaced by FSSA)
SE	Systems Engineer
SLMB	Specified low-income Medicare beneficiary
SNF	Skilled Nursing Facility
SOBRA	Sixth Omnibus Budget Reconciliation Act of 1986
SOD	State Operations Division
TDOS	To Date of Service
TPL	Third Party Liability
UB-92	Uniform Bill – 92

Claim Types

Table 1-1.3 lists several claim types used throughout this manual. They are provided in this table as a reference.

Table 1-1.3 – Claim Types

Claim Type	Description
A	UB-92 INST CROSSOVER CLAIMS
B	HCFA 1500 CROSSOVER CLAIMS
C	UB-92 OUTP CROSSOVER CLAIMS
D	DENTAL CLAIMS
H	HOME HEALTH CLAIMS
I	INPATIENT CLAIMS
L	LONG TERM CARE CLAIMS
M	HCFA 1500 CLAIMS
O	OUTPATIENT CLAIMS
P	PHARMACY CLAIMS
Q	COMPOUNDS DRUG CLAIMS

Teleprocessing Users Guide

For clarification on specific fields in the Error Disposition Windows, refer to the Teleprocessing Users (TPU) Guide.

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